BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: CARYN BETH THOMPSON a.k.a. CARYN BETH JONES 1040 W. Grand #119 Porterville, CA 93257 Registered Nurse License No. 391284 Respondent.	Case No. 2007-240 OAH No. 2007080655

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Board of Registered Nursing as its Decision in the above-entitled matter.

This Decision shall become effective on **March 21, 2008.**

IT IS SO ORDERED **February 21, 2008**.

LaFrancine W Tate

President
Board of Registered Nursing
Department of Consumer Affairs
State of California

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: CARYN BETH THOMPSON a.k.a. CARYN BETH JONES, Registered Nurse License No. 391284, Respondent.	Case No. 2007-240 OAH No. 2007080655

PROPOSED DECISION

Administrative Law Judge Cheryl R. Tompkin, State of California, Office of Administrative Hearings, heard this matter on November 6, 2007, in Oakland, California.

Attorney Leslie Brast represented complainant Ruth Ann Terry, M.P.H., R.N.

Respondent Caryn Beth Thompson appeared and represented herself.

The record was held open to permit counsel for complainant to submit the signed declaration of Lory McLellan. The declaration was received on November 15, 2007, and substituted in evidence for the unsigned declaration of Lory McLellan previously marked as Exhibit 5. The matter was deemed submitted on November 15, 2007.

FACTUAL FINDINGS

1. Complainant Ruth Ann Terry, R.N., M.P.H., made the Accusation in her official capacity as Executive Officer, Board of Registered Nursing (Board), Department of Consumer Affairs.

2. On August 31, 1985, the Board issued license number 391284 to Caryn Beth Thompson, also known as Caryn Beth Jones (respondent). The license was in full force and effect at all times relevant to this proceeding. It will expire on November 30, 2008, unless renewed.

Santa Rosa Memorial Hospital

3. Respondent worked as a traveling nurse at Santa Rosa Memorial Hospital in Santa Rosa, California during November and December 2001. As set forth below, on multiple occasions while working at Santa Rosa Memorial, respondent accessed the hospital's medication dispensing system (PYXIS),[1] but failed to document or account for the administration or disposition of the controlled substances she obtained. Respondent also falsified hospital records, obtained Morphine for administration to a fictitious patient and failed to safeguard her confidential PYXIS access code from another registered nurse, respondent's husband John Michael Jones (Jones), who was also working as a traveling nurse at Santa Rosa Memorial. Jones used respondent's PYXIS access code to access the PYXIS system and obtain controlled substances without authorization and in violation of the law.

4. Lory McLellan is a registered nurse licensed to practice in California. McLellan is the Emergency Department Nurse Manager at Santa Rosa Memorial Hospital and supervised respondent during November and December 2001. In December 2001 McLellan performed a review of respondent's removal of medications from the PYXIS medication dispensing device. McLellan compared respondent's removal of medications with the charts of the patients who were documented in the PYXIS as having received controlled substances. The review revealed that respondent, while on duty as a registered nurse at Santa Rosa Memorial Hospital, signed out controlled substances and failed to properly document the removal in the hospital records as follows:

a. On or about November 30, 2001, at approximately 1512 hours (3:12 p.m.), respondent obtained a 10 mg. vial of Morphine, a controlled substance, for administration to a fictitious patient, and thereafter failed to properly document or account for the 10mg. vial of Morphine.

b. On or about December 3, 2001, at approximately 1013 hours (10:13 a.m.), respondent obtained a 10 mg. vial of Morphine for administration to Patient # SV0004381139. At approximately 1020 hours (10:20 a.m.), respondent documented administration of 3 mg. of Morphine on the patient's medication administration record (MAR), but failed to properly document or otherwise account for the remaining 7 mg. of Morphine.

c. On or about December 3, 2001, at approximately 1444 hours (2:44 p.m.), respondent obtained three 4 mg. syringes of Morphine for administration

[1] PYXIS is the brand name for an automated medication dispensing system. A PIN access code is used to access controlled substances from the system, which automatically logs all transactions and identifies the name of the person accessing the system, the name of the patient for whom the substance has been obtained, and the date, time and dosage obtained.

to Patient #SV0004381477. Respondent documented administration of one 4 mg. syringe of Morphine on the patient's MAR, but failed to properly document or otherwise account for the remaining 8 mg. (two syringes) of Morphine.

d. On or about December 3, 2001, at approximately 1542 hours (3:42 p.m.), respondent obtained two 50 mg. vials of Demerol, a controlled substance, for administration to Patient #SV0004381439. At approximately 1647 hours (4:47 p.m.), respondent documented administration of "Demerol 25mg. IV" on the patient's MAR. Respondent falsely documented that 75 mg. of the Demerol had been wasted. The documentation indicated the wastage was witnessed by registered nurse Jones, respondent's husband.

e. On or about December 3, 2001, at approximately 1819 hours (6:19 p.m.), respondent obtained one 1 mg. syringe of Dilaudid, a controlled substance, for administration to Patient #SV0004381671. Respondent failed to document administration of the Dilaudid to the patient. At approximately 1822 hours (6:22 p.m.), respondent falsely documented that one 1 mg. syringe of Dilaudid had been dropped. The documentation indicated the wastage was witnessed by registered nurse Jones, respondent's husband.

f. On or about December 5, 2001, at approximately 0930 hours (9:30 a.m.), respondent falsely recorded that she had wasted two Darvocet tablets, which had been obtained at approximately 0856 hours (8:56 a.m.) that day by registered nurse Jones, respondent's husband. Darvocet is a controlled substance.

5. McLellan concluded that respondent was diverting narcotic medication. Respondent was discharged from Santa Rosa Memorial Hospital and a complaint was filed with the Board by Blaine S. Guinn, Director of Pharmacy for Santa Rosa Memorial Hospital.

Delano Regional Medical Center

6. During April, May and June of 2002, respondent was employed as a traveling nurse at Delano Regional Medical Center in Delano, California. As set forth below, on multiple occasions while working at Delano Regional, respondent obtained controlled substances without a physician's order, obtained controlled substances for administration to a fictitious patient and a deceased patient, and obtained controlled substances for patient administration but failed to document or account for the administration or disposition of the controlled substances she obtained. Respondent also failed to safeguard her confidential PYXIS access code from another registered nurse, her husband Jones, who was also working as a traveling nurse at Delano Regional. Jones used respondent's PYXIS access code to

access the PYXIS system and obtain controlled substances without authorization and in violation of the law.

7. Between January and December 2002, Pamela R. Ott was a registered nurse licensed to practice in California, and the Director of Nursing at Delano Regional Medical Center. Ott supervised respondent during April, May and June of 2002. At the time of hire respondent produced a positive drug test. Respondent stated that she was taking Lortab (Vicodin) for a knee injury. Her private physician verified this. On June 25, 2002, Ott performed a review of respondent's removal of medications from the hospital's PYXIS medication dispensing device. Ott discovered respondent had removed medications without a physician's order and had failed to document them as dispensed to the patient. As set forth below, there were at least eight separate instances of improper or unauthorized removal of narcotic medication from the hospital's PYXIS system:

a. On or about May 24, 2002, at approximately 1959 hours (7:59 p.m.), respondent obtained a 7.5 mg. Lortab tablet for administration to deceased patient #5801535. The patient had died on March 28, 2002. Respondent failed to properly document or otherwise account for the 7.5 mg. Lortab tablet. Lortab is a controlled substance.

   On or about June 1, 2002, at approximately 0227 hours (2:27 a.m.), respondent obtained two 7.5 mg. Lortab tablets for administration to deceased patient #5801535. Respondent failed to properly document or otherwise account for the two 7.5 mg. Lortab tablets.

b. On or about May 17, 2002, at approximately 2237 hours (10:37 p.m.), respondent obtained a 5 mg./1 ml. vial of Morphine for fictitious patient #5912704 (John Jones). Respondent failed to properly document or otherwise account for the 5 mg./1 mg. vial of Morphine.

   On or about May 17, 2002, at approximately 2346 hours (11:46 p.m.), respondent obtained, without a physician's order, a APAP 500 #8 packet of Vicodin/Lortab for administration to fictitious Patient #5912704 (John Jones). Respondent failed to properly document or otherwise account for the APAP 500 #8 pack of Vicodin/Lortab tablets.

c. On or about May 12, 2002, at approximately 0028 hours (12:28 a.m.), respondent obtained, without a physician's order, four 7.5 mg. Vicodin/Lortab tablets for Patient #ER051202002805. Respondent failed to properly document or otherwise account for the four 7.5 mg. Vicodin/Lortab tablets.

d. On or about May 31, 2002, at approximately 2103 hours (9:03 p.m.), respondent obtained, without a physician's order, two Percodan tablets

for administration to Patient C. Respondent failed to properly document or otherwise account for the two Percodan tablets.

e. On or about June 1, 2002, at approximately 1723 hours (5:23 p.m.), respondent obtained, without a physician's order, two Vicodin/Lortab tablets for administration to Patient D. Respondent failed to properly document or otherwise account for the two Vicodin/Lortab tablets.

f. On or about June 1, 2002, at approximately 1928 hours (7:28 p.m.), respondent obtained, without a physician's order, two Vicodin/Lortab tablets for administration to Patient E. Respondent failed to properly document or otherwise account for two Vicodin/Lortab tablets.

g. On or about June 1, 2002, at approximately 2243 hours (10:43 p.m.), respondent obtained, without a physician's order, a Percocet tablet for administration to Patient F. Respondent failed to properly document or otherwise account for the Percocet tablet.

h. On or about June 2, 2002, at approximately 0228 hours (2:28 a.m.), respondent obtained, without a physician's order, two Vicodin/Lortab tablets for administration to Patient G. Respondent failed to properly document or otherwise account for the two Vicodin/Lortab tablets.

i. On or about June 2, 2002, at approximately 0453 hours (4:53 a.m.), respondent obtained, without a physician's order, two Vicodin/Lortab tablets for administration to Patient H. Respondent failed to properly document or otherwise account for the two Vicodin/Lortab tablets.

j. On or about June 2, 2002, at approximately 1708 hours (5:08 p.m.), respondent obtained, without a physician's order, two 7.5 mg. Vicodin/Lortab tablets for administration to Patient #5856430. Respondent failed to properly document or otherwise account for the two 7.5 mg. Vicodin/Lortab tablets.

8. Ott confronted respondent shortly after her review of respondent's PYXIS activities. Respondent told Ott that respondent's husband, registered nurse Jones, must have gotten access to her PYXIS password and used it. Ott researched the schedule of Jones during the period of unauthorized or improper PYXIS withdrawals. Jones was not working on at least four of the eight occasions of unauthorized or improper withdrawals. Ott concluded that respondent was diverting narcotic medication. Respondent was suspended until she reported her problem to the Board, completed a Board-approved drug treatment program and was participating in regular, ongoing treatment. Respondent never returned to work at Delano Regional Medical Center.

9. The standard of practice requires that registered nurses provide for the health, welfare and safety of patients and safeguard the five rights of a patient when administering medications. Prior to administering medication a nurse must check that she has (1) the right drug, (2) the right dose, (3) the right route, (4) the right time and (5) the right patient. Complainant's expert, Cathy Horowitz, opined that respondent's repeated and extreme departure from the five rights, including improper withdrawal of controlled substances and erroneous documentation of controlled substance administration and disposition, was an extreme departure from the standard of care, and constituted unprofessional conduct and gross negligence within the meaning of California Code of Regulations, title 16, section 1442.[2] Horowitz noted that respondent's actions were intentional, repeated and in direct violation of her obligation as a nurse because respondent's actions involved willful and intentional acquisition of controlled substances through theft, fraud and deceit. Respondent's actions also involved furnishing controlled substances to herself or others without physician orders, which Horowitz opined was inconsistent with the public health, safety and welfare. The testimony of complainant's expert was persuasive.

10. At hearing respondent admitted that she stole or diverted medication during her employment at Santa Rosa Memorial Hospital and Delano Regional Medical Center. Respondent claims she stole the medication for her husband, an addict, because he beat her if she did not bring home Morphine or pills. Respondent testified that she initially resisted her husband's demands but acquiesced after her first beating by him. She feels that she was vulnerable to Jones' influence and threats because they had moved away from her family and friends shortly after their marriage. The violence began soon after the move. Jones would slap her and shove her around; the abuse was typically related to his demands for narcotics. Respondent admits routinely bringing home pills but maintains she only stole injectables (a 4 mg. vial of Morphine) once. Respondent claims to never have actually seen her husband use drugs, but admits she knew he was an addict and also admits that she knew, at least subconsciously, that when he was signing for wastage, he was probably taking some. Respondent also acknowledges that she never reported her husband's addiction to anyone and never sought help from the police with respect to his physical abuse.

11. Respondent denies ever willingly giving her PYXIS access code to her husband. She speculates that he may have gotten it off the back of her nurse's identification

---

[2] California Code of Regulations, title 16, section 1442 provides:

> As used in Section 2761 of the code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

badge, where she sometimes wrote her access codes. However, she admits she failed to properly safeguard her access code from her husband.

12. Respondent's admits trying pills on a couple of occasions but denies she is addicted or has a substance abuse problem.

13. Respondent maintains that she is an excellent nurse. She points out that she has been licensed since 1985 and that she has no history of license discipline or problems at work before her marriage to Jones in March 2001, or after their separation in November 2003, when Jones entered a drug diversion program. She is now divorced from Jones. Respondent asserts she is willing to do whatever is necessary in order to retain her license, including participating in counseling, taking classes or complying with any other condition imposed by the Board.

Other Matters

14. There is no direct evidence that respondent obtained controlled substances for her personal use. However, complainant's expert opines respondent is currently unsafe to practice nursing. She opines respondent displays many of the classic symptoms of narcotic dependency, including continued substance use despite persistent legal and vocation problems directly caused by the substance, large time investment to obtain the substance, denial that chemical dependency is a problem, and blaming others and rationalizing behavior. The expert also opined respondent poses a risk to the public because respondent withdrew controlled substances in excess of doctor's orders and had wastage witnessed by someone she knew to be an addict (her husband) or failed to document wastage; respondent failed to properly document and/or otherwise account for wastage and medications withdrawn from PYXIS or obtained without a doctor's order; respondent consistently failed to comply with security measures by failing to safeguard her PYXIS access code; and respondent repeatedly chose to work with her husband, an addict and failed to report his addiction (thereby avoiding her responsibility to the public) even though she knew his impairment could endanger himself, patients, or others.

15. In mid-September 2007 respondent began working at North Kern State Prison in Delano, California after a 13-month hiatus.[3] Respondent works as a night nurse, primarily responding to sick calls and emergencies. She transports patients to the emergency room and helps as needed. Respondent represents that she only has routine access to Maalox, Tylenol and Motrin. Respondent works 40 hours per week. Respondent has not disclosed the Accusation or subject disciplinary proceedings to her current employer.

---

[3] Respondent testified that she was depressed and did not work for 13 months after she was fired from Delano Regional. During that time she saw a therapist and was taking Prozac. Respondent no longer takes Prozac and is not currently under a physician's care.

Costs

16. Pursuant to Business and Professions Code section 125.3, the Board may request that "a licentiate found to have committed a violation or violations of the licensing act [be required] to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case." The Board certifies that the following costs were incurred in connection with the investigation and prosecution of this Accusation as of November 1, 2007:

Deputy Attorney General:

2005-2006	3.75 hours @ $146.00	$ 574.00
2006-2007	30 hours @ $158/hour	4,740.00
2007-2008	21.25 hours @ $158/hour	4,937.00

Investigation:

2001-2002	4.75 hours @ $128/hour	608.00
2002-2003	19.25 hours @$127/hour	2,444.75
2002-2003	13 hours @ $127/hour	1,651.00
2003-2004	4.75 hours @ $144/hour	684.00
2004-2005	23 hours @ $173/hour	3,979.00

Experts:

2004-2005	10 hours @ $75/hour	900.00
2005-2006	12 hours @ $75/hour	750.00

Legal Assistant Team:

2005-2006	17.75 hours @ $92/hour	1,633.00
2006-2007	13 hours @ $101/hour	1,313.00
	TOTAL COSTS INCURRED:	$24,187.75

17. Respondent did not object to the Board's costs.

LEGAL CONCLUSIONS

1. "The purpose of an administrative proceeding concerning the revocation or suspension of a license is not to punish the individual; the purpose is to protect the public from dishonest, immoral, disreputable or incompetent practitioners." (*Ettinger v. Board of Medical Quality Assurance* (1982) 139 Cal.App.3d 853, 856.)

2. Absent a statute to the contrary, the burden of proof in disciplinary administrative proceedings rests upon the party making the charges. (*Parker v. City of Fountain Valley* (1981) 127 Cal.App.3d 99, 113; Evid. Code § 115.) The burden of proof in this proceeding is on complainant.

3. The standard of proof in administrative disciplinary proceedings brought against professional licensees is "clear and convincing proof to a reasonable certainty." (*James v. Board of Dental Examiners* (1985) 172 Cal.App.3d 1096, 1105.) "The key element of clear and convincing evidence is that it must establish a high probability of the existence of the disputed fact, greater than proof by a preponderance of the evidence." (*People v. Mabini* (2001) 92 Cal.App.4th 654, 662.) This standard is less stringent than proof beyond a reasonable doubt. (*Ettinger v. Board of Medical Quality Assurance, supra*, 135 Cal.App.3d at 856.)

4. Business and Professions Code section 2761, subdivision (a)(1), defines unprofessional conduct to include incompetence or gross negligence in carrying out usual certified or licensed nursing functions. Subdivision (d) of that same section defines unprofessional conduct to include violating, assisting in or abetting violation of the Nursing Practice Act or regulations adopted pursuant to it.

Business and Professions Code section 2762, subdivision (a), defines unprofessional conduct to include obtaining or possessing in violation of law, self-administering or furnishing or administering to another, any controlled substance, except as directed by a licensed physician, surgeon or podiatrist. Subdivision (e) of that same section defines unprofessional conduct to include falsifying or making grossly incorrect or inconsistent entries in any hospital or patient record.

Health and Safety Code section 11173, subdivision (a), provides no person shall obtain controlled substances or procure or attempt to procure the administration of controlled substances by fraud, deceit, misrepresentation, subterfuge or concealment of a material fact.

5. Cause for disciplinary action against respondent exists under Business and Professions Code section 2762, subdivision (e), on the ground of unprofessional conduct, in that respondent made grossly incorrect entries in hospital and patient records pertaining to controlled substances, as set forth in Findings 3, 4, 6 and 7.

6. Cause for disciplinary action against respondent exists under Business and Professions Code section 2762, subdivision (a), on the ground of unprofessional conduct, in that respondent, while working as a registered nurse, obtained dangerous drugs by fraud, deceit, misrepresentation, subterfuge or concealment of material facts, in violation of Health and Safety Code section 11173, subdivision (a), as set forth in Findings 3, 4, 6 and 7.

7. Cause for disciplinary action against respondent exists under Business and Professions Code section 2762, subdivision (a), on the ground of unprofessional conduct, in

that respondent, while working as a registered nurse, possessed controlled substances without a prescription, in violation of Business and Professions Code section 4060, as set forth in Findings 3, 4, 6 and 7.

8. Cause for disciplinary action against respondent exists under Business and Professions Code section 2761, subdivision (d), for unprofessional conduct, in that respondent assisted and/or abetted violations of Business and Professions Code section 2762, subdivision (a) (obtaining controlled substances), as set forth in Findings 3, 4, 6, 7 and 10.

9. Cause for disciplinary action against respondent exists under Business and Professions Code section 2761, subdivision (a)(1), for unprofessional conduct, in that respondent committed acts of gross negligence within the meaning of California Code of Regulations, title 16, section 1442, as set forth in Finding 9.

10. Although respondent engaged in unprofessional conduct while employed as a registered nurse, it is nevertheless determined that revocation of her nursing license is not required. Respondent has been a registered nurse for over 22 years and has no prior history of license discipline. While respondent clearly acted improperly in diverting drugs, her misconduct was directly related to a difficult personal relationship with an addict that has now been terminated. Respondent admits diverting the drugs was wrong, although she seems to feel the fact she did so to avoid being beat by her husband should excuse her conduct, a contention that is not found to be persuasive. However, there is no direct evidence of personal substance dependency or use and respondent denies same. And to the extent respondent's past conduct suggests potential drug use, any concern can be addressed by requiring her to participate in a Board approved Treatment/Rehabilitation Program for Chemical Dependence and random drug testing. After considering all of the evidence, it is determined that the public can be adequately protected by a period of probation with appropriate terms and conditions.

11. Business and Professions Code section 125.3 provides that respondent may be ordered to pay the Board "a sum not to exceed the reasonable costs of the investigation and enforcement of the case." That section also provides that the Board's certification of the actual costs constitutes prima facie evidence of the reasonable costs. The costs set forth in Finding 16 were established by such a certification and respondent did not object to the costs. The reasonable costs of investigation and enforcement are therefore determined to be $24,187.75.

ORDER

IT IS HEREBY ORDERED that Registered Nurse License Number 391284 issued to respondent Caryn Beth Thompson is revoked. However, the revocation is stayed and respondent is placed on probation for three (3) years on the following conditions.

SEVERABILITY CLAUSE – Each condition of probation contained herein is a separate and distinct condition. If any condition of this Order, or any application thereof, is declared unenforceable in whole, in part, or to any extent, the remainder of this Order, and all other applications thereof, shall not be affected. Each condition of this Order shall separately be valid and enforceable to the fullest extent permitted by law.

1. Obey All Laws – Respondent shall obey all federal, state and local laws. A full and detailed account of any and all violations of law shall be reported by respondent to the Board in writing within seventy-two (72) hours of occurrence. To permit monitoring of compliance with this condition, respondent shall submit completed fingerprint forms and fingerprint fees within 45 days of the effective date of the decision, unless previously submitted as part of the licensure application process.

   Criminal Court Orders: If respondent is under criminal court orders, including probation or parole, and the order is violated, this shall be deemed a violation of these probation conditions, and may result in the filing of an accusation and/or petition to revoke probation.

2. Comply with the Board's Probation Program – Respondent shall fully comply with the conditions of the Probation Program established by the Board and cooperate with representatives of the Board in its monitoring and investigation of respondent's compliance with the Board's Probation Program. Respondent shall inform the Board in writing within no more than 15 days of any address change and shall at all times maintain an active, current license status with the Board, including during any period of suspension.

   Upon successful completion of probation, respondent's license shall be fully restored.

3. Report in Person – Respondent, during the period of probation, shall appear in person at interviews/meetings as directed by the Board or its designated representatives.

4. Residency, Practice, or Licensure Outside of State – Periods of residency or practice as a registered nurse outside of California shall not apply toward a reduction of this probation time period. Respondent's probation is tolled, if and when she resides outside of California. Respondent must provide written notice to the Board within 15 days of any change of residency or practice outside the state, and within 30 days prior to re-establishing residency or returning to practice in this state.

Respondent shall provide a list of all states and territories where she has ever been licensed as a registered nurse, vocational nurse, or practical nurse. Respondent shall further provide information regarding the status of each license and any changes in such license status during the term of probation. Respondent shall inform the Board if she applies for or obtains a new nursing license during the term of probation.

5. Submit Written Reports – Respondent, during the period of probation, shall submit or cause to be submitted such written reports/declarations and verification of actions under penalty of perjury, as required by the Board. These reports/declarations shall contain statements relative to respondent's compliance with all the conditions of the Board's Probation Program. Respondent shall immediately execute all release of information forms as may be required by the Board or its representatives.

   Respondent shall provide a copy of this decision to the nursing regulatory agency in every state and territory in which she has a registered nurse license.

6. Function as a Registered Nurse – Respondent, during the period of probation, shall engage in the practice of registered nursing in California for a minimum of 24 hours per week for 6 consecutive months or as determined by the Board.

   For purposes of compliance with the section, "engage in the practice of registered nursing" may include, when approved by the Board, volunteer work as a registered nurse, or work in any non-direct patient care position that requires licensure as a registered nurse.

   The Board may require that advanced practice nurses engage in advanced practice nursing for a minimum of 24 hours per week for 6 consecutive months or as determined by the Board.

   If respondent has not complied with this condition during the probationary term, and respondent has presented sufficient documentation of her good faith efforts to comply with this condition, and if no other conditions have been violated, the Board, in its discretion, may grant an extension of the respondent's probation period up to one year without further hearing in order to comply with this condition. During the one year extension, all original conditions of probation shall apply.

7. Employment Approval and Reporting Requirements – Respondent shall obtain prior approval from the Board before commencing or continuing any employment, paid or voluntary, as a registered nurse. Respondent shall cause to be submitted to the Board all performance evaluations and other employment related reports as a registered nurse upon request of the Board.

Respondent shall provide a copy of this decision to her employer and immediate supervisors prior to commencement of any nursing or other health care related employment.

In addition to the above, respondent shall notify the Board in writing within seventy-two (72) hours after she obtains any nursing or other health care related employment. Respondent shall notify the Board in writing within seventy-two (72) hours after she is terminated or separated, regardless of cause, from any nursing, or other health care related employment with a full explanation of the circumstances surrounding the termination or separation.

8. Supervision – Respondent shall obtain prior approval from the Board regarding respondent's level of supervision and/or collaboration before commencing or continuing any employment as a registered nurse, or education and training that includes patient care.

Respondent shall practice only under the direct supervision of a registered nurse in good standing (no current discipline) with the Board of Registered Nursing, unless alternative methods of supervision and/or collaboration (e.g., with an advanced practice nurse or physician) are approved.

Respondent's level of supervision and/or collaboration may include, but is not limited to the following:

(a) Maximum – The individual providing supervision and/or collaboration is present in the patient care area or in any other work setting at all times.

(b) Moderate – The individual providing supervision and/or collaboration is in the patient care unit or in any other work setting at least half the hours respondent works.

(c) Minimum – The individual providing supervision and/or collaboration has person-to-person communication with respondent at least twice during each shift worked.

(d) Home Health Care – If respondent is approved to work in the home health care setting, the individual providing supervision and/or collaboration shall have person-to-person communication with respondent as required by the Board each work day. Respondent shall maintain telephone or other telecommunication contact with the individual providing supervision and/or collaboration as required by the Board during each work day. The individual providing supervision

and/or collaboration shall conduct, as required by the Board, periodic, on-site visits to patients' homes visited by respondent with or without respondent present.

9. Employment Limitations – Respondent shall not work for a nurse's registry, in any private duty position as a registered nurse, a temporary nurse placement agency, a traveling nurse, or for an in-house nursing pool.

Respondent shall not work for a licensed home health agency as a visiting nurse unless the registered nursing supervision and other protections for home visits have been approved by the Board. Respondent shall not work in any other registered nursing occupation where home visits are required.

Respondent shall not work in any health care setting as a supervisor of registered nurses. The Board may additionally restrict respondent from supervising licensed vocational nurses and/or unlicensed assistive personnel on a case-by-case basis.

Respondent shall not work as a faculty member in an approved school of nursing or as an instructor in a Board approved continuing education program.

Respondent shall work only on a regularly assigned, identified and predetermined worksite(s) and shall not work in a float capacity.

If respondent is working or intends to work in excess of 40 hours per week, the Board may request documentation to determine whether there should be restrictions on the hours of work.

10. Complete a Nursing Course(s) – Respondent, at her own expense, shall enroll and successfully complete a course(s) relevant to the practice of registered nursing no later than six months prior to the end of her probationary term.

Respondent shall obtain prior approval from the Board before enrolling in the course(s). Respondent shall submit to the Board the original transcripts or certificates of completion for the above required course(s). The Board shall return the original documents to respondent after photocopying them for its records.

11. Cost Recovery – Respondent shall pay to the Board costs associated with its investigation and enforcement pursuant to Business and Professions Code section 125.3 in the amount of $24,187.75. Respondent shall be permitted to pay these costs in a payment plan approved by the Board, with payments to be completed no later than three months prior to the end of the probation term.

12. Violation of Probation – If a respondent violates the conditions of her probation, the Board after giving the respondent notice and an opportunity to be heard, may set aside the stay order and impose the stayed discipline (revocation) of respondent's license.

If during the period of probation, an accusation or petition to revoke probation has been filed against respondent's license or the Attorney General's Office has been requested to prepare an accusation or petition to revoke probation against respondent's license, the probationary period shall automatically be extended and shall not expire until the accusation or petition has been acted upon by the Board.

13. License Surrender – During respondent's term of probation, if she ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the conditions of probation, respondent may surrender her license to the Board. The Board reserves the right to evaluate respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances, without further hearing. Upon formal acceptance of the tendered license and wall certificate, respondent will no longer be subject to the conditions of probation.

Surrender of respondent's license shall be considered a disciplinary action and shall become a part of respondent's license history with the Board. A registered nurse whose license has been surrendered may petition the Board for reinstatement no sooner than the following minimum periods from the effective date of the disciplinary decision:

1. Two years for reinstatement of a license that was surrendered for any reason other than a mental or physical illness; or

2. One year for a license surrendered for a mental or physical illness.

14. Physical Examination – Within 45 days of the effective date of this decision, respondent, at her expense, shall have a licensed physician, nurse practitioner, or physician assistant, who is approved by the Board before the assessment is performed, submit an assessment of respondent's physical condition and capability to perform the duties of a registered nurse. Such an assessment shall be submitted in a format acceptable to the Board. If medically determined, a recommended treatment program will be instituted and followed by respondent with the physician, nurse practitioner, or physician assistant providing written reports to the Board on forms provided by the Board.

If respondent is determined to be unable to practice safely as a registered nurse, the licensed physician, nurse practitioner, or physician assistant

making this determination shall immediately notify the Board and respondent by telephone, and the Board shall request that the Attorney General's office prepare an accusation or petition to revoke probation. Respondent shall immediately cease practice and shall not resume practice until notified by the Board. During this period of suspension, respondent shall not engage in any practice for which a license issued by the Board is required until the Board has notified respondent that a medical determination permits respondent to resume practice. This period of suspension will not apply to the reduction of this probationary time period.

If respondent fails to have the above assessment submitted to the Board within the 45-day requirement, respondent shall immediately cease practice and shall not resume practice until notified by the Board. This period of suspension will not apply to the reduction of this probationary time period. The Board may waive or postpone this suspension only if significant, documented evidence of mitigation is provided. Such evidence must establish good faith efforts by respondent to obtain the assessment, and a specific date for compliance must be provided. Only one such waiver or extension may be permitted.

15. Participate in Treatment/Rehabilitation Program for Chemical Dependence – Respondent, at her expense, shall successfully complete during the probationary period or shall have successfully completed prior to commencement of probation a Board-approved treatment/rehabilitation program of at least six months duration. As required, reports shall be submitted by the program on forms provided by the Board. If respondent has not completed a Board-approved treatment/rehabilitation program prior to commencement of probation, respondent, within 45 days from the effective date of the decision, shall be enrolled in a program. If a program is not successfully completed within the first nine months of probation, the Board shall consider respondent in violation of probation.

Based on Board recommendation, each week respondent shall be required to attend at least one, but no more than five 12-step recovery meetings or equivalent (e.g., Narcotics Anonymous, Alcoholics Anonymous, etc.) and a nurse support group as approved and directed by the Board. If a nurse support group is not available, an additional 12-step meeting or equivalent shall be added. Respondent shall submit dated and signed documentation confirming such attendance to the Board during the entire period of probation. Respondent shall continue with the recovery plan recommended by the treatment/rehabilitation program or a licensed mental health examiner and/or other ongoing recovery groups.

16. Abstain from Use of Psychotropic (Mood-Altering) Drugs – Respondent shall completely abstain from the possession, injection or consumption by

any route of all psychotropic (mood altering) drugs, including alcohol, except when the same are ordered by a health care professional legally authorized to do so as part of documented medical treatment. Respondent shall have sent to the Board, in writing and within fourteen (14) days, by the prescribing health professional, a report identifying the medication, dosage, the date the medication was prescribed, respondent's prognosis, the date the medication will no longer be required, and the effect on the recovery plan, if appropriate.

Respondent shall identify for the Board a single physician, nurse practitioner or physician assistant who shall be aware of respondent's history of substance abuse and will coordinate and monitor any prescriptions for respondent for dangerous drugs, controlled substances or mood-altering drugs. The coordinating physician, nurse practitioner, or physician assistant shall report to the Board on a quarterly basis respondent's compliance with this condition. If any substances considered addictive have been prescribed, the report shall identify a program for the time limited use of any such substances.

The Board may require the single coordinating physician, nurse practitioner, or physician assistant to be a specialist in addictive medicine, or to consult with a specialist in addictive medicine.

17. Submit to Tests and Samples – Respondent, at her expense, shall participate in a random, biological fluid testing or a drug screening program which the Board approves. The length of time and frequency will be subject to approval by the Board. Respondent is responsible for keeping the Board informed of respondent's current telephone number at all times. Respondent shall also ensure that messages may be left at the telephone number when she is not available and ensure that reports are submitted directly by the testing agency to the Board, as directed. Any confirmed positive finding shall be reported immediately to the Board by the program and respondent shall be considered in violation of probation.

In addition, respondent, at any time during the period of probation, shall fully cooperate with the Board or any of its representatives, and shall, when requested, submit to such tests and samples as the Board or its representatives may require for the detection of alcohol, narcotics, hypnotics, dangerous drugs, or other controlled substances.

If respondent has a positive drug screen for any substance not legally authorized and not reported to the coordinating physician, nurse practitioner, or physician assistant, and the Board files a petition to revoke probation or an accusation, the Board may suspend respondent from practice pending the final

decision on the petition to revoke probation or the accusation. This period of suspension will not apply to the reduction of this probationary time period.

If respondent fails to participate in a random, biological fluid testing or drug screening program within the specified time frame, respondent shall immediately cease practice and shall not resume practice until notified by the Board. After taking into account documented evidence of mitigation, if the Board files a petition to revoke probation or an accusation, the Board may suspend respondent from practice pending the final decision on the petition to revoke probation or the accusation. This period of suspension will not apply to the reduction of this probationary time period.

18. Mental Health Examination – Respondent shall, within 45 days of the effective date of this decision, have a mental health examination including psychological testing as appropriate to determine her capability to perform the duties of a registered nurse. The examination will be performed by a psychiatrist, psychologist or other licensed mental health practitioner approved by the Board. The examining mental health practitioner will submit a written report of that assessment and recommendations to the Board. All costs are the responsibility of respondent. Recommendations for treatment, therapy or counseling made as a result of the mental health examination will be instituted and followed by respondent.

If respondent is determined to be unable to practice safely as a registered nurse, the licensed mental health care practitioner making this determination shall immediately notify the Board and respondent by telephone, and the Board shall request that the Attorney General's office prepare an accusation or petition to revoke probation. Respondent shall immediately cease practice and may not resume practice until notified by the Board. During this period of suspension, respondent shall not engage in any practice for which a license issued by the Board is required, until the Board has notified respondent that a mental health determination permits respondent to resume practice. This period of suspension will not apply to the reduction of this probationary time period.

If respondent fails to have the above assessment submitted to the Board within the 45-day requirement, respondent shall immediately cease practice and shall not resume practice until notified by the Board. This period of suspension will not apply to the reduction of this probationary time period. The Board may waive or postpone this suspension only if significant, documented evidence of mitigation is provided. Such evidence must establish good faith efforts by respondent to obtain the assessment, and a specific

date for compliance must be provided. Only one such waiver or extension may be permitted.

19. Therapy or Counseling Program – Respondent, at her expense, shall participate in an on-going counseling program until such time as the Board releases her from this requirement and only upon the recommendation of the counselor. Written progress reports from the counselor will be required at various intervals.

DATED: 12/17/07

CHERYL R. TOMPKIN
Administrative Law Judge
Office of Administrative Hearings

EDMUND G. BROWN JR., Attorney General
of the State of California
FRANK H. PACOE
Supervising Deputy Attorney General
LESLIE E. BRAST, State Bar No. 203296
Deputy Attorney General
California Department of Justice
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-5548
Facsimile: (415) 703-5480

Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **CARYN BETH THOMPSON,** **a.k.a. CARYN BETH JONES** 1040 W. Grand #119 Porterville, CA 93257 Registered Nurse License No. 391284, Respondent.	Case No. 2007-240 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

2. On or about August 31, 1985, the Board issued Registered Nurse License Number 391284 to Caryn Beth Thompson, also known as Caryn Beth Jones ("Respondent"). The license will expire on November 30, 2008, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code ("Code") unless otherwise indicated.

4. Code section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

STATUTORY PROVISIONS

6. Code section 2761 provides, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.
>
> . . .
>
> (d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice Act] or regulations adopted pursuant to it.

7. Code section 2762 provides, in pertinent part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
>
> . . .
>
> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

8. Code section 4022 provides:

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use in humans or animals, and includes the following:

(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006.

9. Code section 4060 provides:

No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, a physician assistant pursuant to Section 3502.1, a naturopathic doctor pursuant to Section 3640.5, or a pharmacist pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052. This section shall not apply to the possession of any controlled substance by a manufacturer, wholesaler, pharmacy, pharmacist, physician, podiatrist, dentist, optometrist, veterinarian, naturopathic doctor, certified nurse- midwife, nurse practitioner, or physician assistant, when in stock in containers correctly labeled with the name and address of the supplier or producer.

10. Health and Safety Code section 11173, subdivision (a), provides:

(a) No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the concealment of a material fact.

11. Code section 125.3 provides that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

REGULATORY PROVISIONS

12. California Code of Regulations, title 16, section 1442, provides:

> As used in Section 2761 of the code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

DRUGS

13. "Darvocet" is a compound consisting of acetaminophen and propoxyphene napsylate, and is a Schedule IV controlled substance as designated by Health and Safety Code section 11057, subdivision (c)(2), and a dangerous drug within the meaning of Code section 4022.

14. "Demerol" is a compound containing Meperdine Hydrochloride, and is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c)(17), and a dangerous drug within the meaning of Code section 4022.

15. "Dilaudid" is a brand of hydromorphone, and is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(K), and a dangerous drug within the meaning of Code section 4022.

16. "Lortab" is a compound containing Hydrocodone, and is a Schedule III controlled substance as designated by Health and Safety Code section 11056, subdivision (e)(4), and a dangerous drug within the meaning of Code section 4022.

17. "Morphine" is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M), and a dangerous drug within the meaning of Code section 4022.

18. "Percocet" is a brand of oxycodone and is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(N), and a dangerous drug within the meaning of Code section 4022.

//

19. "Percodan" is a brand of oxycodone and is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(N), and a dangerous drug within the meaning of Code section 4022.

20. "Vicodin" is a compound consisting of acetaminophen and hydrocodone bitartrate, also known as dihydrocodeinone, and is a Schedule III controlled substance as designated by Health and Safety Code section 11056, subdivision (e)(4), and a dangerous drug within the meaning of Code section 4022.

Background

21. Santa Rosa Memorial Hospital. During November and December 2001, Respondent worked as a traveling nurse at Santa Rosa Memorial Hospital (SRMH), located in Santa Rosa, California. As set forth below, on multiple occasions while working at SRMH, Respondent obtained controlled substances for patient administration by accessing the hospital's medication dispensing system(Pyxis)[1], but failed to document or account for the administration or disposition of those controlled substances. Respondent also falsified hospital records, obtained Morphine for administration to a fictitious patient, and failed to safeguard her confidential Pyxis access code, which was used by her husband, John Michael Jones, who was also working as a traveling nurse at SRMH, to access the hospital's Pyxis and obtain controlled substances in violation of law.

22. Delano Regional Medical Center. During April, May and June 2002, Respondent worked as a traveling nurse at Delano Regional Medical Center (DRMC), located in Delano, California. As set forth below, on multiple occasions while working at DRMC, Respondent obtained controlled substances without a physician's order to do so, obtained controlled substances for administration to a fictitious patient and a deceased patient, and obtained controlled substances for patient administration, but failed to document or account for

---

1. Pyxis is a brand name for an automated medication dispensing and supply system. A PIN access code is used to access controlled substances from the Pyxis system which automatically logs all transactions identifying the name of the person accessing the system, the name of the patient for whom the substance has been obtained, and the date, time and dosage being obtained.

the administration of those substances. Respondent also failed to safeguard her confidential Pyxis access code, which was used by her husband, John Michael Jones, who was also working as a traveling nurse at DRMC, to access the hospital's Pyxis and obtain controlled substances in violation of law.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: False, Grossly Incorrect, Grossly Inconsistent Record Entries)

23. Respondent is subject to disciplinary action under Code section 2762, subdivision (e), for unprofessional conduct in that she made false, grossly incorrect, or grossly inconsistent entries in hospital, patient, or other records pertaining to controlled substances, as follows:

a. Santa Rosa Memorial Hospital:

1. Fictitious Patient #1. On or about November 30, 2001, at approximately 1512 hours, Respondent obtained a 10mg vial of Morphine for administration to Fictitious Patient #1. Thereafter, Respondent failed to properly document or otherwise account for the 10mg vial of Morphine.

2. Patient #SV0004381139. On or about December 3, 2001, at approximately 1013 hours, Respondent obtained a 10mg. vial of Morphine for administration to Patient #SV0004381139. At approximately 1020 hours, Respondent documented the administration of 3mg. of Morphine on the patient's medication administration record ("MAR"). Respondent failed to properly document or otherwise account for the remaining 7mg. of Morphine.

3. Patient #SV0004381477. On or about December 3, 2001, at approximately 1444 hours, Respondent obtained three 4mg. syringes of Morphine for administration to Patient #SV0004381477. Respondent documented the administration of one 4mg. syringe of the Morphine on the patient's MAR (time uncertain). Respondent failed to properly document or otherwise account for the two remaining syringes of Morphine.

//

4. Patient #SV0004381439. On or about December 3, 2001, at approximately 1542 hours, Respondent obtained two 50mg. vials of Demerol for administration to Patient #SV0004381439. At approximately 1605 hours, Respondent documented the administration of "Demerol 25mg. IV" on the patient's MAR. At approximately 1647 hours, Respondent falsely documented that 75mg. of the Demerol had been wasted. The wastage was witnessed by Registered Nurse John Michael Jones, Respondent's husband.

5. Patient #SV0004381671. On or about December 3, 2001, at approximately 1819 hours, Respondent obtained one 1mg. syringe of Dilaudid for administration to Patient #SV0004381671. Respondent failed to document administration of the substance to the patient. At approximately 1822 hours, Respondent falsely documented that one 1mg. syringe of the Dilaudid had been "dropped," which was witnessed by Registered Nurse John Michael Jones, Respondent's husband.

6. Patient #SV0004382505. On or about December 5, 2001, at approximately 0930 hours, Respondent falsely recorded that she had wasted two Darvocet tablets, which had been obtained at approximately 0856 hours that day by Registered Nurse John Michael Jones, Respondent's husband.

b. Delano Regional Medical Center:

1. Patient #5801535.

A. On or about May 24, 2002, at approximately 1959 hours, Respondent obtained a 7.5mg. Lortab tablet for administration to deceased Patient #5801535; the patient had died on March 28, 2002. Thereafter, Respondent failed to properly document or otherwise account for the 7.5mg. Lortab tablet.

B. On or about June 1, 2002, at approximately 0227 hours, Respondent obtained two 7.5mg. Lortab tablets for administration to deceased Patient #5801535, failing to properly document or otherwise account for the two 7.5mg. Lortab tablets.

//

//

2. Fictitious Patient #5912704 (John Jones).

A. On or about May 17, 2002, at approximately 2237 hours, Respondent obtained a 5mg./1ml. vial of Morphine for Fictitious Patient #5912704 (John Jones). Respondent failed to properly document or otherwise account for the 5mg.1ml. vial of Morphine.

B. On or about May 17, 2002, at 2346 hours, Respondent obtained, without a physician's order to do so, a APAP 500 5 #8 pak of Vicodin/Lortab for administration to Fictitious Patient #5912704 (John Jones). Respondent failed to properly document or otherwise account for the APAP 500 5 #8 pak of Vicodin/Lortab.

3. Patient #ER051202002805. On or about May 12, 2002, at approximately 0028 hours, Respondent obtained, without a physician's order to do so, four 7.5mg. Vicodin/Lortab tablets for Patient #ER051202002805. Respondent failed to properly document or otherwise account for the four 7.5mg. Vicodin/Lortab tablets.

4. Patient "C." On or about May 31, 2002, at approximately 2103 hours, Respondent obtained, without a physician's order to do so, two Percodan tables for administration to Patient "C." Respondent failed to properly document, or otherwise account for the two Percodan tablets.

5. Patient "D." On or about June 1, 2002, at approximately 1723 hours, Respondent obtained, without a physician's order to do so, two Vicodin/Lortab tablets for administration to Patient "D." Respondent failed to properly document or otherwise account for the of two Vicodin/Lortab tablets.

6. Patient "E." On or about June 1, at approximately 1928 hours, Respondent obtained, without a physician's order to do so, two Vicodin/Lortab tablets for administration to Patient "E." Respondent failed to properly document or otherwise account for the two Vicodin/Lortab tablets.

7. Patient "F." On or about June 1, 2002, at approximately 2243 hours, Respondent obtained, without a physician's order to do so, a Percocet tablet for administration to Patient "F." Respondent failed to properly document or otherwise account for the Percocet tablet.

8. Patient "G." On or about June 2, 2002, at approximately 0228 hours, Respondent obtained, without a physician's order to do so, two Vicodin/Lortab tablets for administration to Patient "G." Respondent failed to properly document or otherwise account for the two Vicodin/Lortab tablets.

9. Patient "H." On or about June 2, 2002, at approximately 0453 hours, Respondent obtained, without a physician's order to do so, two Vicodin/Lortab tablets for administration to Patient "H." Respondent failed to properly document or otherwise account for the two Vicodin/Lortab tablets.

10. Patient #5856430. On or about June 2, 2002, at approximately 1708 hours, Respondent obtained, without a physician's order to do so, two 7.5mg. Vicodin/Lortab tablets for administration to patient #5856430. Respondent failed to properly document or otherwise account for the two 7.5mg.Vicodin/Lortab tablets.

SECOND CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Wrongfully Obtaining Controlled Substances)

24. Respondent is subject to disciplinary action under Code section 2762, subdivision (a), for unprofessional conduct in that, while working as a Registered Nurse at two hospitals, she obtained dangerous drugs by fraud, deceit, misrepresentation, subterfuge, or by the concealment of material facts, in violation of Health and Safety Code section 11173, subdivision (a), as detailed in paragraphs 23 (a) and (b), above.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Wrongful Possession of Controlled Substances)

25. Respondent is subject to disciplinary action under Code section 2762, subdivision (a), for unprofessional conduct in that, while working as a Registered Nurse at two hospitals, she possessed, without a prescription in violation of Code section 4060, Morphine, Percodan, Vicodin/Lortab, and Percocet–all controlled substances. The circumstances are detailed in paragraphs 23 (a) and (b), above.

FOURTH CAUSE FOR DISCIPLINE

(Assisting in and/or Abetting Violations of the Nursing Practice Act)

26. Respondent is subject to disciplinary action under Code section 2761, subdivision (d), for assisting and/or abetting in violations of Code section 2762, subdivision (a) (obtaining controlled substances in violation of law), as follows:

a. During November and December 2001, while working as a Registered Nurse at Santa Rosa Memorial Hospital, Respondent allowed Registered Nurse John Michael Jones, her husband, the use of her confidential code to access the hospital's Pyxis and obtain controlled substances by fraud, deceit, misrepresentation, subterfuge, or by the concealment of material facts, in violation of Health and Safety Code section 11173, subdivision (a).

b. During April, May, and June 2002, while working as a Registered Nurse at Delano Regional Medical Center, Respondent allowed Registered Nurse John Michael Jones, her husband, the use of her confidential code to access the hospital's Pyxis and obtain controlled substances by fraud, deceit, misrepresentation, subterfuge, or by the concealment of material facts, in violation of Health and Safety Code section 11173, subdivision (a).

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence)

27. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1), for unprofessional conduct in that she committed acts of gross negligence within the meaning of California Code of Regulations, title 16, section 1442, as follows:

a. Santa Rosa Memorial Hospital:

1. On multiple occasions during November and December 2001, while working as a Registered Nurse at SRMH, Respondent withdrew controlled substances and failed to properly document or account for the disposition of those substances.

2. During November and December 2001, while working at SRMH, Respondent failed to safeguard and protect her confidential Pyxis access code against unauthorized use.

b. Delano Regional Medical Center:

1. On multiple occasions during April, May, and June 2002, while working as a Registered Nurse at DRMC, Respondent withdrew controlled substances and failed to properly document or account for the disposition of those substances.

2. During April, May, and June 2002, Respondent failed to safeguard and protect her confidential Pyxis access code against unauthorized use.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing the Board issue a decision:

1. Revoking or suspending Registered Nurse License Number 391284, issued to Caryn Beth Thompson, also known as Caryn Beth Jones;

2. Ordering Caryn Beth Thompson, also known as Caryn Beth Jones, to pay the reasonable costs incurred by the Board in the investigation and enforcement of this case pursuant to Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: 3/26/07

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SF2006400106
40128136.wpd